Bureau of Health Care Quality and Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NV2981AGC | A. BUILDING _____ B. WING _____ | 10/13/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOME AWAY FROM HOME | 1235 GLENDA WAY RENO, NV 89509 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Y 000 | Initial Comments<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 10/13/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received a re-survey grade of A.<br><br>The facility is licensed for 20 Residential Facility for Group beds for elderly and disabled persons, twelve beds Category I and eight beds Category II residents. The census at the time of the survey was seven. One resident file was reviewed.<br><br>No further regulatory deficiencies were identified. | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE